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The Affordable Care Act and Tax Policy

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The Affordable Care Act fails to coordinate the impact of tax burdens on individuals with the global aim of extending the availability of health care insurance. The price of private health insurance depends in this country on who buys it; large employers pay less than small employees and individuals for the same level of coverage. Because the ACA does not eliminate these and related artefactual cost differences, the Act's price-based adjustments of the post-tax cost of health care to individuals simply perpetuate or worsen central problems of tax fairness and neutrality.

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I. INTRODUCTION

If a rational health care policy on its own is not easy to construct, the difficulty is compounded when tax policy must be factored into the equation. This country, of course, takes a mixed public/private approach to health care,[1] a wistful form of pragmatism that reflects the absence of consensus over what our national health care policy should be.[2] As things stood, health care insurance and self-insurance regularly interacted with the taxation of individuals' purchased and un-purchased health gains.[3] The Patient Protection and Affordable Care Act of 2010 ("ACA")[4] promises to make our mixed approach more systematic, by intervening in these private health care markets that are already significantly tax-driven. The ACA , as part of its attempt to organize and rationalize health care policy,[5] must accordingly confront the interaction of health care policy and tax policy.

Making sense of the intersection of these two policy areas is only one of the ACA's many goals, and, although well intentioned, the Act does a

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[1] *See* Lance Gable, *The Patient Protection and Affordable Car Act, Public Health, and the Elusive Target of Human Rights*, 39 J.L. MED. & ETHICS 340, 342 (2011) ("[T]he inherent complexity of the United States health care system, with its public private structure and multiple participants, demands detailed, voluminous legislation . . . .").

[2] *See* Robert J. Blendon & John M. Benson, *Americans' Views on Health Policy: A Fifty-Year Historical Perspective*, 20 HEALTH AFF. 33, 36 (2001) ("Among the confounding factors is the lack of an underlying consensus among the American public over the preferred type of national health plan.").

[3] *See* Robert B. Helms, *Tax Policy and the History of the Health Insurance Industry* 17–18 (Am. Enterprise Inst., Feb. 29, 2008), *available at* http://www.aei.org/papers/health/healthcare-reform/private-insurance/tax-policy-and-the-history-of-the-health-insurance-industry/ (describing the relationship between tax policy and health care insurance, focusing particularly on how tax policy increases the demand for group health insurance).

[4] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of 21, 25, 26, 29, 30, and 42 U.S.C.), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of 20, 26, and 42 U.S.C.).

[5] *See* KAREN DAVIS ET AL., STARTING ON THE PATH TO A HIGH PERFORMANCE HEALTH SYSTEM: ANALYSIS OF THE PAYMENT AND SYSTEM REFORM PROVISIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 xiv–xv (2010), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Sep/1442_Davis_Payment%20and%20System%20Reform_923v2.pdf (stating that the measures incorporated in the ACA would "stimulate significant changes in the organization and delivery of health services and create powerful incentives to improve efficiency and productivity").

poor job in this regard. It fails altogether to take a new look at the problem of evaluating and coordinating the impact of tax burdens and government health initiatives on the well-being of the public, relying instead on inadequate proxies for these purposes.[6] Because the Act tries to work through the private sector to provide a public good, it runs directly into the perennial problems of markets' mis-measurement of utility, non-measurement of opportunity, and utter insensitivity to the mesh of utility and opportunity, which, collectively, are the most plausible measure of well-being.[7] At bottom, what haunts the blind use of economic benchmarks is the old dilemma about whether opportunity or outcomes, or some combination of the two, provide the ultimate criterion of well-being. By failing to approach the problem seriously, the Act fails to integrate tax policy with this major intervention in health care and creates a new range of inequities. The difficult politics of the legislative process obviously persuaded its proponents to accept rough-and-ready solutions[8] that will often have tragic consequences. Desperate advocacy of the primary and admirable goals of the law seemed to excuse the lack of concern for an integrated theoretical solution. Theory, after all, often seems to have nothing to do with the goal of relieving human suffering. But in this instance, theory could have guided the proponents of the ACA to a better, and politically feasible, solution.

The essence of the Act's failure in this regard is that it does not even try to adjust economic consequences to those covered by the new system so that combined out-of-pocket and tax burdens are equal for all. This would of course be easily achieved by a single-payor system, because the benefits would flow to beneficiaries without money changing hands, or with income-adjusted co-pay. The ACA does little to accomplish an equivalent result. Its tax provisions are collectively inequitable and thus out of accord with one of the primary goals of income taxation.

II. THE PROBLEM

What does tax law have to do with health care? Many federal and local taxes have only a small effect on health care markets and outcomes.[9]

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[6] See *infra* Part III.

[7] *See infra* Part III.

[8] *See* Janet L. Dolgin & Katherine R. Dieterich, *Social and Legal Debate About the Affordable Care Act*, 80 UMKC L. REV. 45, 50–51 (2011) (describing the political circumstances of the ACA's passage).

[9] There are currently no excise taxes on the ingredients of health care delivery. *See* JANE G. GRAVELLE, CONG. RESEARCH SERV., R40648, TAX OPTIONS FOR FINANCING HEALTH CARE REFORM, (2010) (listing prospective excises taxes and implicitly noting that no current excise taxes affect health care delivery). The background economic consequences of the income, gift, and estate taxes are so diffuse that they do not affect the economy as a whole measurably. *See* JOEL SLEMROD & JOHN BAKIJA, TAXING OURSELVES: A CITIZEN'S GUIDE TO THE DEBATE OVER TAXES 99–157 (4th ed. 2008).

Income taxation is another matter. A tax on income can be an unfair burden on people who must pay for their own, differing health care needs. An income tax that ignores these inherent differences in the cost of health care for each individual will mis-measure income itself and, in a world of high private health care costs, grossly fail to achieve the two main goals of broad direct taxation: fairness and economic neutrality.

To understand why, we must first consider certain broad features of income taxation. A tax on income must distinguish taxpayers' outlays that contribute to the production of income from other outlays.[10] Income-seeking outlays are subtracted from gross revenue in measuring income because income is the flow of new wealth, and costs are, by definition, paid out of old wealth already on hand. This netting of gross income and costs is, however, only one rationale for allowing deductions as part of the computation of taxable income. The deduction of losses, or the exclusion of recoveries for losses, has a different rationale. Unforeseeable and unusual losses that are beyond an individual's control cannot be described as uses of income at all. Gross income that disappears without the owner's involvement is properly subtracted from income, not as a cost of producing it, but as never properly belonging to the flow of new wealth.[11]

Income tax systems always allow extraordinary losses to be deducted (sometimes with restrictions that reflect evidentiary or administrative issues).[12] Arguably, expenses related to health and dying deserve the same treatment, and they should either be deductible or excluded from gross income. There is, however, another argument for adjusting income measurement downward to reflect them. William D. Andrews, and subsequent commentators, have maintained that income spent on health care should not be taxed because these expenses restore the individual's

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Disparity in the income taxation of charitable and for-profit hospitals probably has some effect on health care delivery, but apparently for-profits are increasing in number despite the advantages enjoyed by charitable hospitals. *See generally* William M. Gentry & John R. Penrod, *The Tax Benefits of Not-for-Profit Hospitals*, *in* THE CHANGING HOSPITAL INDUSTRY: COMPARING FOR-PROFIT AND NOT-FOR-PROFIT INSTITUTIONS 285, 285–324 (David M. Cutler ed., 2000). Currently, only the individual income tax has a major effect on health care, by excluding the value of employer-provided health insurance from the gross income of employees and permitting a comparable exclusion to employees who must buy their own, only through the less generous mechanism of health-savings accounts and flexible spending plans. *See infra* notes 104–108 and accompanying text.

[10] *See* STEPHEN UTZ, TAX POLICY: AN INTRODUCTION AND SURVEY OF THE PRINCIPAL DEBATES 90–91 (1993)("[T]he point is to contrast previously available economic resources with newly created ones . . . .").

[11] HENRY C. SIMONS, PERSONAL INCOME TAXATION 50 (1938) ("In other words, [income] is merely the result obtained by addition consumption during the period to 'wealth' at the end of the period and then subtracting 'wealth' at the beginning. The sine qua non of income is *gain*, as our courts have recognized in their more lucid moments—and gain to someone during a specified time interval.").

[12] *See* I.R.C. § 165 (2006) (allowing for deduction of certain unforeseeable losses from gross income, including certain losses in insolvent financial institutions and disaster losses).

basic human endowment, the starting point from which income should be measured.[13] Evidently, this rationale for the deduction of health costs differs from the rationale for deducting losses. Losses must be deducted to prevent the double counting of income—the inclusion of already acquired income along with new income that flowed from the investment of the old in some profit-seeking activity.[14] The purpose of treating healthy and unhealthy people similarly—by allowing the latter to deduct the costs of health care—may be partly, or entirely, to be fair to the unhealthy. We may do so in order to avoid taxing the unhealthy on the benefit of the good health that others enjoy without having to pay to acquire or keep it. In brief, the deduction of health care costs, or the exclusion from income of health care benefits given gratuitously to those who need them, may be akin to the deduction of losses but may also be seen as a leveling measure for the preservation of fairness in the imposition of tax burdens.

The current Code seems to reflect this policy norm by making medical expenses deductible and by making some, but not all, taxpayers' health insurance tax-free (by exclusion or deduction).[15] Yet it makes these tax adjustments unevenly, discriminating against employees whose employers do not provide them with health insurance as an employment benefit.[16]

The ACA alters but does not repair the current tax law's incoherent attempt to exempt medical expenses for insurance or treatment from income tax. Indeed, it exacerbates one feature of current law that contributes to its incoherence and introduces yet further elements of inequality among taxpayers. It is possible that some of this inequality may disappear as health insurance markets respond to the ACA, but any such prediction must be based on highly speculative assumptions about those markets.[17]

These shortcomings of the ACA's attempt to integrate health care policy and tax policy expose a deeper problem related to the American

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[13] William D. Andrews, *Personal Deductions in an Ideal Income Tax*, 86 HARV. L. REV. 309, 331–32, 342–43 (1972). Andrews addresses only the deductibility of medical expenses, but his argument would also support the exclusion of employer-provided health insurance to the extent that the value of this benefit were available to all. Health, as part of the human endowment, poses a broad problem for income taxation. The difficulty of distinguishing what is properly part of the basic human equipment, and what is only a particular expression or use of it, forces legislators and tax administrators to draw arbitrary boundaries between taxable and tax-exempt aspects of human capital. *See* UTZ, *supra* note 10, at 91–96.

[14] *See supra* notes 10–11 and accompanying text.

[15] *See* I.R.C. § 213 (outlining allowable, deductible, medical expenses).

[16] *See* I.R.S. PUB. NO. 15002Q, MEDICAL & DENTAL EXPENSES 9 (Feb. 9, 2012) (providing examples of employer-sponsored health insurance plans).

[17] *See* HENRY J. KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM: EXPLAINING HEALTH CARE REFORM: QUESTIONS ABOUT HEALTH INSURANCE SUBSIDIES 1 (2010), *available at* http://www.kff.org/healthreform/upload/7962-02.pdf (discussing health insurance premium tax credits that will be available to individuals whose employers do not provide them with insurance coverage).

health care market. The balkanization of the health care insurance market between large employer and small employer or single employee policy markets makes the cost of the same health care different for different individuals.[18] Differences attributable to market failure and monopoly within the health insurance market prevent prices from serving as a reliable measure of the health benefits purchased. As a consequence, the current tax treatment of health care outlays, which treats these costs as proper measures of what they pay for, preserves and even worsens the discrepancy between the price and the effect of health care on the individual's well-being.

Several very basic concepts must figure in any useful discussion of legislative justice. The most basic is the concept of well-being, which is the measure of how well-off a person is.[19] If food and lodging make a person better off than she would be without them, they increase her well-being, and their absence would decrease her well-being. Things that are good for a person may affect her well-being differently, some increasing it while others detract from it. Just as importantly, things that might separately add to her well-being may be redundant when combined. For example, the availability of a healthy diet may improve a person's well-being, and so may the freedom to eat according to one's tastes, but the two in combination may not improve well-being by the sum of what each contributed separately.

Well-being is a comparative concept.[20] Levels or states of well-being must be comparable, at least in principle. If two things contribute to one's well-being, their contributions must be comparable in principle.[21] We may not have the information needed for doing so, but to posit that some contributions are incommensurable would be to deny that there is a single

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[18] *See* Allison Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7, 17–19 (2010) (discussing the fragmentation of the American health care market).

[19] JAMES GRIFFIN, WELL-BEING: ITS MEANING, MEASUREMENT, AND MORAL IMPORTANCE 75–76 (1989); DANIEL M. HAUSMAN & MICHAEL S. MCPHERSON, ECONOMIC ANALYSIS AND MORAL PHILOSOPHY 72 (2d ed. 1996).

[20] *See* UTZ, *supra* note 10, at 45–47.

[21] *See* Daniel M. Hausman, *The Impossibility of Interpersonal Utility Comparisons*, 104 MIND 473, 474 (1995) ("[I]f a conception of well-being does not permit one to make interpersonal comparisons in an acceptable way, then that conception of well-being is itself unacceptable."); *see also* Matthew D. Adler & Eric A. Posner, *Rethinking Cost-Benefit Analysis*, 109 YALE L.J. 165, 205–06 (1999) ("[W]e take it to be a condition of the validity of a welfare theory that it warrants some interpersonal comparisons of welfare . . . . The fact that a theory of well-being that (1) makes well-being consist in the satisfaction of bare desires or preferences and (2) incorporates no mechanism for translating the ordinal rankings constituted by desire or preference into some interpersonally comparable form, leads to (3) the impossibility of interpersonal comparisons, does *not* imply that such comparisons are indeed impossible. Rather, it implies that the theory is wrong.").

measure of well-being.[22] But that there should be a single measure is of the essence of our thinking about well-being. We presuppose that there is a common scale of well-being, when we discuss it at all.[23]

We make such comparisons, and presume such a common scale, routinely.[24] When I make up my mind to buy an expensive new car, I expect to be better off owning it, despite being responsible for significant car payments. When I observe my neighbor's purchase of a new car, however, I think that he is mistaken in believing that it will make him better off despite the cost. Our judgments of this sort may be fallible and inconsistent with each other but unless there is some coherence to our practice, the concept of "better off," or higher on the scale of well-being, is bankrupt.[25] All this suggests that it should not be hard to formulate a theoretical account of well-being.

III. THEORIES OF WELL-BEING

A. *Utility Theory*

Since the early nineteenth century, theorists tried to do just that, not through the empirical study of real people and their behavior, but as a normative matter.[26] Their goal was to generalize about how choices and sets of beliefs and preferences *must* be related to each other, if choices based on them are to be minimally rational.[27] Utility theory is what emerged as the consensus view of what reasonable preferences have in

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[22] *See* Matthew D. Adler, *Risk, Death and Harm: The Normative Foundations of Risk Regulation*, 87 MINN. L. REV. 1293, 1333 (2003) ("[I]ntrapersonal judgments of comparative well-being always involve comparisons of multiple outcomes, at least some of which must be merely possible, not actual.").

[23] *See* John Broome, *Cost Benefit Analysis and Population*, 29 J. LEGAL STUD. 953, 960 (2000) (explaining that well-being can be measured on a ratio scale); *see also, e.g.*, John Bronsteen et al., *Welfare as Happiness*, 98 GEO. L.J. 1583, 1636–37 (2010) (discussing the variability and wealth of information necessary to conduct one type of well-being analysis).

[24] *See* Adler & Posner, *supra* note 21, at 205.

[25] *See* Hausman, *supra* note 21, at 476, (explaining that it is difficult, and perhaps impossible, to quantitatively and universally determine how a person would rank their preferences on the spectrum of well-being: "[T]here is no non-arbitrary answer to the question of whether a position in one ordinal ranking is higher than a position in another").

[26] *See* Herbert Hovenkamp, *The Marginalist Revolution in Legal Thought*, 46 VAND. L. REV. 305, 309–11 (1993) (describing the progression of the utility theory of value from its origins with Jeremy Bentham in the 1790s to William Stanley Jevons and Carl Menger and explaining that these utility theories were completely subjective, since they were constructed upon "the individual utility function rather than on any criterion that could be determined from the desired good itself or the environment in which a choice was made").

[27] JOSEPH A. SCHUMPETER, HISTORY OF ECONOMIC ANALYSIS 302–03 (1954) (tracing utility's role is early price theory to Galiani, Say, Quesnay, Beccaria, Turgot, Verri, Condillac and Smith, whom he characterizes as "Benthamites by anticipation").

common.[28]

Utility theory is expressed as a set of postulates about how anyone's preferences must relate to each other in order to be rational.[29] In this regard, utility theory is normative,[30] that is, it purports to prescribe what rational preferences must be like, without presuming that the preferences of actual people are usually or ever rational.[31] Utility theory is about people's preferences among events or states of affairs that might happen.[32] "Utility" is, thus, an invented concept that begins as a place-holder with no content, and the theory tries to fill in that content.

Utility as a place-holder should not be assumed to be the same as the pleasure or pain or the usefulness of what follows if the preferences are realized. If Jones wants a good meal more than Jones wants to see a movie, the utility of the event Jones-gets-a-good-meal is greater for Jones than the utility of the event Jones-sees-a-movie, both events being scheduled for immediate occurrence. If Jones would rather that the Red Sox win the World Series this year (call this "event A") than that any other team win it ("event B"), the utility for Jones of event A is greater than the utility for Jones of event B. We can sometimes speak of things, rather than events, as having utility,[33] but today utility is commonly understood to belong to things only as they relate to events.[34] For example, an apple can have greater utility for me than a plum would, but what that really means is that my eating an apple would satisfy a stronger preference of mine than the event of my eating a plum.

We must not confuse utility with the anticipated pleasure or happiness an event will cause someone. A person can strongly prefer things that will

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[28] *See* JOHN BROOME, WEIGHING GOODS: EQUALITY, UNCERTAINTY AND TIME 91 (1991) ("[U]tility theory intends to describe the preferences a person would have if she were rational.").

[29] *See* DANIEL M. HAUSMAN, THE INEXACT AND SEPARATE SCIENCE OF ECONOMICS 18 (1992) (describing the theory of rational preference).

[30] *Id.* at 19.

[31] HAUSMAN & MCPHERSON, *supra* note 19, at 49.

[32] UTZ, *supra* note 10, at 46.

[33] *See* Daniel Kahneman, *Experienced Utility and Objective Happiness: A Moment-Based Approach*, *in* CHOICES, VALUES AND FRAMES 673, 673 (D. Kahneman & A. Tversky eds., 2000) ("As Bentham (1789) used it, utility refers to the experiences of pleasure and pain, the 'sovereign masters' that 'point out what we ought to do, as well as determine what we shall do.'"); Arie Kapteyn, *Utility and Economics*, 133 DE ECONOMIST 1, 1 (1985) ("By utility is meant that property in any object, whereby it tends to produce benefit, advantage, pleasure, good or happiness . . . ."); *see generally* John Broome, "*Utility*", 7 ECON. & PHIL. 1 (1991).

[34] *See* Kahneman, *supra* note 33, at 673 ("In modern decision research, however, the utility of outcomes refers to their weight in decisions: utility is inferred from observed choices and is in turn used to explain choices."); Kapteyn, *supra* note 33, at 2 ("In modern economic theory, this is not the common way the utility concept is introduced. Nowadays the *preference ordering* is taken as a primitive term. An individual's preference ordering ranks alternatives in order of preference. . . . 'Utility' is no longer a primitive term, but it is defined in terms of preferences [of actions or decisions].").

not cause her pleasure or happiness, at least as pleasure and happiness are normally understood.[35] A remorseful wrongdoer may prefer to be caught and punished, even though in every ordinary sense of the word, this would not make him happy or cause him pleasure. To say that being caught would give him a special kind of pleasure or happiness stretches the meaning of these words so much that it is better just to coin a new term—and that is why "utility" is introduced.

The formal character of utility—that anything can have higher or lower utility as long as this is the individual's preference—is both a highly prized feature of utility theory and a source of trouble for it.[36] If utility is formal rather than substantive, we can lay down no rules about the relative value of earlier or later events in someone's life, and, in particular, we cannot assume or insist that what happens later is of greater value than what happens earlier. This leads to a paradox, however: we can say that the total utility of A's life experiences is greater than the total utility of B's life experiences even though A's preferences were satisfied only in early life and not at all in later life, and B's "hard" early years were succeeded by a completely happy later life. Since this is possible in a purely formal utility theory, it would follow that someone could rationally pursue an early-good-later-bad set of outcomes. This seems paradoxical.

Other paradoxes that we will not examine here beset the formal character of utility theory.[37] It is enough to say that the hoped-for advantages of a relatively undemanding formal theory of rational preference have not been clearly achieved. Yet utility theory continues to be used in economic theorizing, including tax policy analysis, despite this shortcoming.[38] What is its significance? That utility theory is not free of implicit normative bias, at least as applied by even pure theorists, when they begin to consider concrete examples.

Another respect in which utility theory has been seen as normative is the common assumption of the possibility of "interpersonal comparisons" of utility.[39] Some, not all, believe that since no way of measuring degrees

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[35] *See* Richard A. Posner, *Utilitarianism, Economics, and Legal Theory*, 8 J. LEGAL STUD. 103, 112–13 (1979) ("The chief thing which the common-sense individual actually wants is not satisfactions for the wants which he has, but more, and *better* wants.").

[36] *See* HAUSMAN & MCPHERSON, *supra* note 19, 119–28 (explaining that individual experiences cannot be compared but even if it is assumed that individual experiences can be compared, and doing so would enhance social utility, it does not follow that individuals ought to compare their experiences); DEREK PARFIT, REASONS AND PERSONS 365–66 (1986).

[37] HAUSMAN & MCPHERSON, *supra* note 19, at 55–59 (discussing Allais's paradox and other controversies concerning utility theory).

[38] *See, e.g.*, Louis Kaplow, *Taxation, in* 1 HANDBOOK OF LAW AND ECONOMICS 647, 652–70 (Mitchell Polinsky & Steven Shavell eds., 2007).

[39] *See* JAMES A. MIRRLEES, *The Economic Uses of Utilitarianism, in* WELFARE, INCENTIVES AND TAXATION 69, 75–79 (James A. Mirrlees ed., 2006) (applying the utility of an individual to evaluate societal outcomes where individuals are identical); *see also* Ian B. Lee, *Efficiency and Ethics in the*

of utility permits the utility of an event for one person to be compared with the utility of an event for another person, the utility of the same event (whether ordinal or cardinal) for more than one person is unknowable.[40] Lionel Robbins famously declared that this makes utility a "normative" concept, in the sense that we must postulate that the impossible is in fact possible.[41] If this means anything, it is that when we say of a group of people, for example, the population of this country, that they are better off if their drinking water is fluoridated than if it is not, we are treating what people say about their preferences as good enough evidence of objectively shared preferences to put our doubts about inter-subjective comparisons of utility to rest.[42]

When not concerned with these foundational aspects of utility theory, economists have often been content to assume that the prices people would be willing to pay for goods and services, as revealed indirectly by the prices they do actually pay, in turn reveal the utility these goods and services have for the individuals in question. On these assumptions, welfare becomes shorthand for economic results. Naturally, recourse to consumer behavior as a reliable measure of utility and well-being is usually hedged round with caveats. But it persists as a routine element in cost-benefit analysis, the vernacular counterpart of utility theory.[43]

B. *Alternatives to Utility Theory*

In recent years, this traditional conception of welfare has come in for strong criticism, much of it from economists themselves.[44] Some have emphasized that this overly individualistic approach to understanding welfare leaves out social factors that may be central to an individual's well-being. John Rawls grounds his *Theory of Justice* in a thorough-going

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Debate About Shareholder Primacy, 31 DEL. J. CORP. L. 533, 569 (2006) ("Because the costs and benefits fall on different groups, any assessment of the net social welfare impact is *prima facie* impossible without an interpersonal utility comparison, and such comparisons are impermissible within welfare economics.").

[40] *See* LIONEL ROBBINS, AN ESSAY ON THE NATURE AND SIGNIFICANCE OF ECONOMIC SCIENCE 125–26 (1932) (giving an example of a line of thought stemming from comparing human experience).

[41] *See* Ioannis Lianos, *'Judging' Economists: Economic Expertise in Competition Law Litigation: A European View*, *in* THE REFORM OF EC COMPETITION LAW: NEW CHALLENGES 185, 207 n.142 (Ioannis Lianos & Ioannis Kokkoris eds., 2010) (noting that Robbins believed utility to be a normative rather than descriptive question).

[42] *See* ROBBINS, *supra* note 40, at 122–24 (discussing how the theory of exchange compares orders of preferences among different people, but also how there is no way to test the satisfaction of two separate people).

[43] *See* HAUSMAN & MCPHERSON, *supra* note 19, at 94–99.

[44] *See, e.g.*, Yew-Kwang Ng, From Preference to Happiness: Towards a More Complete Welfare Economics 1–5 (Feb. 2000), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=222059 (criticizing preference utilitarianism as failing to go deeper to analyze the overall welfare of an individual).

critique of utility theory as a theory of well-being.[45] Rawls's conclusion is that some "goods" or types of aspiration cannot be placed on the same scale, and hence, well-being must not be a matter of outcomes.[46] He advances a view of well-being that measures government's impact on well-being in terms of the opportunities government makes available, with outcomes as a somewhat remote factor to be considered in evaluating these opportunities.[47] By contrast with classical utility theory, Rawls replaces what a person actually gets out of life with what a person has the chance of getting out of life as the criterion of fairness and justice.[48] Note that Rawls does not try to formulate a more fundamental theory of well-being, one that could be used to explain what it is to be better or worse off apart from society's intervention in our lives.

Amartya Sen, an important rival to Rawls, thinks that both opportunity and outcomes are important.[49] Sen believes that this is due in part to the failure of welfarism (as he calls the economists' conception of welfare preference satisfaction) to take into account the role of the individual's capacities in determining how well-off the individual is.[50] Someone without the ability to do things for himself or herself cannot be said to be as well-off, Sen believes, as someone with basic life skills as well as other skills that may be prized in the particular society.[51] Education, in our society, arguably vies with the size of your paycheck as a determinant of your welfare in this broader sense that Sen has tried to identify. Since his conception of welfare places that notion somewhere between an exclusive emphasis on the intrinsic value of preference satisfaction, i.e., a pure result-oriented view of welfare, and an opportunity or ability view, it has been dubbed "midfare" by friendly commentators.[52]

Given the non-match of well-being with preference satisfaction, how relevant are economic data in measuring well-being? Market values are

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[45] *See* JOHN RAWLS, A THEORY OF JUSTICE 177–78 (1971) (arguing that when the principle of utility is satisfied, there is no guarantee that everyone in society will benefit).

[46] *See id.* at 92–93 (explaining that rational individuals value certain primary goods, such as rights, liberties, and opportunities over other goods).

[47] *See id.* at 275 (advocating that government should create equal opportunities for all individuals throughout society by engaging in activities such as establishing public schools, policing private firms to prevent monopolies, and providing a social safety net).

[48] *See id.* at 259–60 ("[A just] social system shapes the wants and aspirations that its citizens come to have. It determines the sort of persons they want to be as well as the sort of persons they are.").

[49] *See* AMARTYA SEN, THE IDEA OF JUSTICE 18–19 (2009) (describing the importance of social realizations and individual capabilities in ensuring well-being).

[50] *See id.* at 278 (discussing how welfarism suffers from a lack of interpersonal comparisons of utility amongst individuals).

[51] *Cf. id.* at 282–83 (suggesting that the utility experienced by a disadvantaged person is not the same as a more fortunate individual in society because the former learns to adjust their desires and expectations downward).

[52] JOHN E. ROEMER, THEORIES OF DISTRIBUTIVE JUSTICE 189 (1996).

themselves not trustworthy guides even to preference satisfaction, which is the underlying subject matter of utility theory, because competitive markets set prices that correspond to the strength of the marginal purchaser's preference, ignoring the possibly greater preferences (utilities) of intramarginal purchasers.[53] But even this shortcoming does not hint at the gross discrepancy Sen identified between well-being (or quality of life) and market results. Early on, relying on his expertise as a development economist, Sen pointed out that despite the steady and rapid growth of individual income in the early industrial revolution, more people endured more suffering than during the pre-industrial period.[54] While the utility-based conception of welfare does not necessarily equate higher incomes with improved welfare, it tends to favor that view because money is the chief instrument by which people in a market-dominated society can satisfy their preferences. The greater ability to satisfy market-oriented preferences that industrialization has brought, Sen argues convincingly, cannot be said to increase welfare.[55]

Another critique of welfarism indicts that concept's insensitivity to the importance of planning, effort, and self-determination in making people better off, not just because these things lead to preference satisfaction, but as valuable objectives themselves.[56] This thought is obviously close to Sen's emphasis on the mix of capacities and consequences in determining welfare, but it also hints at a formal defect in welfare based on utility theory. Planning and effort seem to have no place in a view of welfare that finds value in preference satisfaction, at least if separable utility functions are the benchmark for measuring preference satisfaction. This is because separable utility functions rule out process-oriented preferences. There is nothing wrong, in this view, with identifying welfare with preference satisfaction, but preferences must be allowed to include preferences that events succeed each other in a certain way. Such linked-event preferences, however, are non-separable and hence are beyond the scope of welfare as economics has theorized about it.

It is worthy of note that these criticisms of traditional welfarism pose a challenge to traditional tax policy.[57] In particular, the criticisms imply (1)

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[53] For a discussion of marginal utility, the principle that each additional unit of a good is worth less to the consumer than previous units, see DAVID D. FRIEDMAN, PRICE THEORY: AN INTERMEDIATE TEXT 82–85 (2d ed. 1990).

[54] AMARTYA SEN, DEVELOPMENT AS FREEDOM 72–74 (1999).

[55] *Id.* at 69

[56] *See id.* at 68 ("[T]he assumption of common preference and choice behavior is quite often made in applied welfare economics, and this is frequently used to justify the assumption that everyone has the same utility function. . . . Is that presumption legitimate for the interpretation of utility as a numerical representation of preference? The answer, unfortunately, is in the negative.").

[57] *See, e.g.*, RAWLS, *supra* note 45, at 278–79 ("[A] proportional expenditure tax . . . is preferable to an income tax (of any kind) . . . [and] treats everyone in a uniform way . . . . It may be better, therefore, to use progressive rates only when they are necessary to preserve the justice of the basic

that economic losses, including deadweight losses, cannot be unequivocally treated as losses in collective well-being[58] and (2) that the ability-to-pay approach, as utility theory reframed this originally grass-roots conception, is not at all helpful in analyzing the very difficulties for which it was first introduced, viz., situations in which tax burdens as burdens on well-being are not un-controversially captured by market values.[59]

C. *What Measure Should We Use?*

These meritorious criticisms of utility theory have not yet enabled theorists to formulate a better measure of well-being. We may have learned something about what well-being is not, but this has left us in doubt about what it is. The inconclusive status quo yields another disappointment, though one for which the criticisms of utility theory are not responsible. Theorists of taxation and other aspects of public policy have become so accustomed to the metrical advantages of utility theory that they continue using it, despite its acknowledged defects.[60] To some extent, continued use is justified in modeling analyses of the economic effects of isolated features of tax design, because models are invariably qualified by *ceteris paribus* provisos that caution their audience against drawing any strong practical conclusions from them.[61] Yet less streamlined discussion of broad issues of public policy cannot reasonably proceed without taking account of the criticisms of utility theory, which effectively means adopting a different understanding of well-being.

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structure with respect to the first principle of justice and fair equality of opportunity . . . . Following this rule might help to signal an important distinction in questions of policy.").

[58] *See* Stephen Utz, *Ability to Pay*, 23 WHITTIER L. REV. 867, 921 (2002) (noting that, in his review of the merits of ability to pay doctrine, Richard Musgrave "showed that the attempts of Mill and others to define equal sacrifice functionally ran aground in the shallows of the utilitarian analysis of welfare (welfarism).").

[59] *See* RAWLS, *supra* note 45, at 279–80 ("No mention has been made at any point of the traditional criteria of taxation such as that taxes are to be levied according to . . . ability to pay. The reference to common sense precepts in connection with expenditure taxes is a subordinate consideration. . . . [T]he conventional maxims are seen to have no independent force . . . Inheritance and progressive income taxes, for example, are not predicated on the idea that individuals have similar utility functions."); Utz, *supra* note 58, at 869–70 ("The greater one's ability to pay, the higher the fair tax, and perhaps the higher the fair rate of tax. This much is commonly accepted. . . . Despite this, . . . no useful formulation of ability to pay has escaped devastating criticism.").

[60] *See, e.g.*, John Creedy & Nicolas Hérault, *Welfare-Improving Income Tax Reforms: A Microsimulation Analysis*, 64 OXFORD ECON. PAPERS 128, 129 (2012) ("A . . . fundamental difficulty arises in specifying a suitable welfare metric and social welfare function. In the basic optimal tax model, this is straightforward given the choice of cardinalization of utility.").

[61] *See, e.g.*, Sarah B. Lawsky, *On the Edge: Declining Marginal Utility and Tax Policy*, 95 MINN. L. REV. 904, 914 (2011) ("A moderately egalitarian social welfare function would weight the utility of the less well-off more than the utility of the more well-off, because, all else being equal, such a function would recommend redistribution from the better-off person to the worse-off person.").

The problem of reconciling the effects of different areas of public policy on individuals' well-being can highlight the inadequacy of utility theory. Where health care policy and taxation are concerned, government reliance on private health insurance markets to implement public policy makes the problem of reconciliation particularly difficult.[62] While market prices may sometimes accurately reflect consumer surplus,[63] they are unlikely to do so in the markets that provide health insurance in this country, and even less likely to measure well-being accurately.[64]

If well-being could simply be identified with utility, and the utility of an outcome could be assumed to be accurately measured by the market price an individual pays or would pay to bring that outcome about,[65] then the cost of health insurance would accurately reflect how insurance affects the well-being of those who buy or receive insurance as a job perk. In this country, however, the price of private health insurance depends upon whether an employer provides the health insurance or upon whether the insured buys the insurance directly from an insurer.[66] Before the ACA, it also depended upon whether the insured had a pre-existing medical condition and other factors that are peculiarities of the historical development of U.S. health insurance markets.[67] These price differences seem irrelevant to the contribution the insurance makes to well-being of the insured.[68] Therefore, the prices of health insurance contracts are not

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[62] *See* Stephen Utz, *Federalism in Health Care: A Policy Overview*, 3 HOUS. J. HEALTH L. & POL'Y 161, 167 (2003) ("Private insurers are concerned about the adequacy of a health care package only as a side issue. Their primary concern is profit, which economic theory teaches us cannot be expected to lead in the health field maximization of the general welfare.").

[63] N. GREGORY MANKIW, PRINCIPLES OF MICROECONOMICS 138–39 (4th ed. 2007).

[64] *See* WILLIAM KENNETH BELLINGER, THE ECONOMIC ANALYSIS OF PUBLIC POLICY 30 (2007) (noting the problems associated with basing individual well-being in utility theory); A. MITCHELL POLINSKY, HANDBOOK OF LAW AND ECONOMICS 506 (2007) ("Although basic economic (utility) theory posits that individual well-being is a function of the satisfaction of individual preferences, this notion has been debated in other disciplines, including psychology and philosophy. . . . [Q]uestions have been raised about whether societal gains and losses can be expressed through the simple aggregation of welfare changes of individuals. Some have argued that other factors should be considered in a measure of social well-being . . . .").

[65] *See* MANKIW, *supra* note 63, at 139, 143 (outlining the general conclusions drawn about economic well-being from prices set according to consumer surplus measures).

[66] *See, e.g.*, *Comparison of Expenditures in Nongroup and Employer-Sponsored Insurance: 2004–2007*, KAISER FAM. FOUND. (March 2010), http://www.kff.org/insurance/snapshot/chcm111006oth.cfm ("[N]ongroup policies are providing less coverage than employer-sponsored insurance.").

[67] *See* DAVID F. DRAKE, REFORMING THE HEALTH CARE MARKET: AN INTERPRETIVE ECONOMIC HISTORY 17–20 (1994) (presenting an analysis of the development of the modern health insurance market with a particular focus upon the development of current cost estimating problems).

[68] *See* Willard G. Manning et al., *Health Insurance and the Demand for Medical Care*, 77 AM. ECON. REV. 251, 265 (1987) (concluding that less favorable health care coverage does not decrease the overall health of the covered individual).

reliable proxies for the size of the effects on well-being such health care coverage provides.[69]

D. *How Should We Think About Well-Being in Designing Health Care Policy?*

Private health insurance may also pose a further problem for measuring well-being. Even though insurance coverage may improve an individual's well-being, actual receipt of insurance benefits may have a further effect on the recipient's well-being. People who have such insurance, and have reason to believe they will not need it, may choose not to purchase insurance;[70] they therefore appear, by the equation of utility with preference satisfaction, to enjoy no utility gain by virtue of having health care coverage.[71] People with a family history of ill health or some other adverse risk factor are apparently better off both by virtue of having coverage and by virtue of any actual benefits they receive. Coverage alone should satisfy a preference and receiving actual benefits—not an inevitable consequence of coverage or risk factors—appears to be a separate addition to such an individual's well-being. It is tempting to say that coverage and actual benefits are not separate events and therefore should not be allowed to have cognizably distinct effects on anyone's well-being.[72] The occurrence of the word "should" in the previous sentence, however, alerts us to the danger that this proposition is a norm of unexplained provenance. Where fairness is concerned, however, it is certain that we should not count both coverage and the receipt of benefits as additions to well-being.[73]

The historical dimension of health care policy also deserves notice in this context. If health care were not capable of making large differences in our lives, any attempt by individuals or their governments to provide health benefits would have only a panacea effect.[74] This result might increase

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[69] *See* Michael E. Porter & Elizabeth Olmsted Teisberg, *Redefining Competition in Health Care*, HARV. BUS. REV., June 2004, at 64, 66–67 (2004) (arguing that the insurance industry's competition should occur at the level of prevention and treatment and should not focus upon costs).

[70] *See, e.g.*, TOM BAKER, INSURANCE LAW & POLICY 6 (2d ed. 2008) (explaining the general principle of adverse selection and using the health of the insurance applicant as a primary example).

[71] *See* BELLINGER, *supra* note 64, at 59–70 (analyzing the relationship between consumption and utility).

[72] *See* Jay A. Soled, *Taxation of Employer-Provided Health Coverage: Inclusion, Timing, and Policy Issues*, 15 VA. TAX REV. 447, 454 (1996) ("In assessing a person's material well-being . . . [e]xpenditures made to attain this baseline [termed 'good health'] do not represent *real* consumption insofar as the person making such expenditures is no better off than his healthy, untaxed peers.").

[73] *See id.* ("In fact . . . the exact opposite is true: as evidenced by [a] person's medical expenditures, the person lacks material well-being and, therefore, has less of an ability to pay tax.").

[74] *See* Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 TUL. L. REV. 777, 779 (2006) (noting that "[t]he United States spends more on health care than any

collective and individual well-being but the effect would be much less significant than that of efficacious health care. Fairness would be a slight concern. The opposite seems true of societies, like those of the wealthy countries of our time, which can easily provide effective health care at an affordable governmental cost.[75] Yet it is not true generally that when a society can provide a benefit, its refusal to do so must be regarded as unfair.[76]

Given these complicating factors, the reconciliation of health care policy and tax policy would be easiest if all health care were provided in kind by the government. Although the treatment actually received would differ, because health needs differ and no rationally administered health care system would provide the same treatment to all without regard to need,[77] the goal of the system would be to bring every individual to the same basic level of good health, so that while some individuals would benefit more than others, all would be brought as nearly as possible to the same basic health endowment. There would be no private health care market with respect to what is necessary for this goal, although there could conceivably be a private health care market for other unnecessary treatment (e.g., elective cosmetic surgery). The ability of individuals to achieve the same basic health endowment would not depend on their incomes or other economic attributes, and there would accordingly be no need to adjust income tax rules to avoid discrepant treatment that would burden some taxpayers more than others in ways that might affect their

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other country both on a per capita basis and as a share of national income, yet our health outcomes lag behind many other countries who spend far less").

[75] *But see* Lawrence O. Gostin et al., *Restoring Health to Health Reform: Integrating Medicine and Public Heath to Advance the Population's Well-Being*, 159 U. PA. L. REV. 1777, 1781 (2011) (noting that the United States ranks thirty-seventh among global health systems, falling "behind countries with half the income and half the health care expenditures per capita").

[76] *See* Erika Blacksher et al., *Public Values, Health Inequality, and Alternative Notions of a "Fair" Response*, 35 J. HEALTH POL. POL'Y & L. 889, 890–91 (2010) (contrasting government action to remedy health care in England, where "health inequalities are cast as unfair and their remedy a matter of social justice," with that of the United States, where "arguments grounded in notions of fairness would be unhelpful . . . [because] most Americans value individual traits such as initiative, freedom, and self-reliance" that create "a greater willingness to tolerate economic inequalities"); Amanda Littell, Note, *Can a Constitutional Right to Health Guarantee Universal Health Care Coverage or Improved Health Outcomes?: A Survey of Selected States*, 35 CONN. L. REV. 289, 307–08 (2002) (arguing that the U.S. Constitution "does not provide a right to health or health care" and that although the preamble "recognizes the state duty to promote the public good, the text leaves the implementation of this duty to legislative discretion" (footnote omitted)).

[77] For the *locus classicus* of the theory that health care markets inevitably fail to function in accordance with the classical view of markets because of information asymmetry between providers and patients, see Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963). *See also* UTZ, *supra* note 10, at 167–74 (outlining how "important features of governmentally financed health benefits are shaped by the decisions of private firms" and discussing the often competing and distinct goals of cost containment, efficiency, and expanding health insurance coverage).

receipt of the basic health care provided under the government health program.

Fairness in health care requires that individuals have an equal realistic opportunity to achieve the same level of health care—the same basic health care endowment. Medical science does not make it possible for everyone to become equally healthy, even if unlimited resources were available to deliver the best possible health care. Some diseases cannot be cured; some congenital health defects are irreversible. It seems reasonable to assume, however, that if everything possible is done to prevent health endowment differences from affecting the quality of peoples' lives, that is all fairness requires. If a government provided system of health care met this standard, the government's intervention in the health of the population would satisfy the demands of justice, without having to be coordinated with any other government intervention in the lives of the population, such as the imposition of tax burdens.

Although this proposition concerning the fairness or justice of a governmentally sponsored health care system does not specify a metric of well-being capable of replacing utility-based explications of well-being, it does provide a different kind of measuring rod for assessing the fairness of other governmentally sponsored health care systems.

IV. THE INTERACTION OF HEALTH CARE AND TAX PROGRAMS UNDER THE ACA

The principled integration of health care and tax concerns for fairness and efficiency raises some of the most intransigent public policy issues. If a society provides no health care benefits at all for its members, but imposes any taxes, the tax burden may hinder the fair or efficient delivery of health care by the private sector. If the government acts by nontax measures to better private sector health care delivery, to make it fairer or to improve it in some other respect, it must take into account both health care needs as they might stand in the absence of taxation and the effect of taxes on improving or worsening the pre-tax situation.[78] Provision of health care benefits directly by the government of course could avoid part of the problem of rectifying the complex effect of taxes on private health care markets.[79] Government subsidies and penalties intended to persuade individuals and markets to achieve rational public health care goals must cope with behavior that is unlikely to be entirely rational, given the

[78] *See* Arrow, *supra* note 77, at 947–48.

[79] *See* Clark C. Havighurst & Barak D. Richman, *The Provider Monopoly Problem in Health Care*, 89 OR. L. REV. 847, 858–61, 866–67 (2011) (discussing some of the tax issues encountered by private health care providers).

proverbial informational asymmetry between providers and consumers.[80] But it must also evaluate and, if necessary, adjust tax burdens that would gum the works of otherwise reasonable governmental intervention in private health care transactions.

Fairness[81], where health care is concerned, must be based on need. A fair health care system does not foist treatment on those who do not need it, and cannot wait until the needs of all are evident before responding to emergencies. Differentiated treatment can nevertheless be fair if it brings all individuals to the same level of good health or provides the same level of care to the dying and to those whose health cannot be brought up to a desirable level. A fair tax system, on the other hand, is arguably one that imposes equal burdens or exacts equal sacrifices from all individuals, where burden or sacrifice means utility loss. In other words, a dominant tradition in tax policy has interpreted fairness in terms of welfare measured by utility. Other views of welfare seem more appropriate for the development of an acceptable public health care policy precisely because the final impact of such a policy on different individuals, in treatment terms, must attempt to reflect differences in the utility of specific health care interventions for different individuals.

Income taxation has a peculiar feature that stands in the way of achieving fairness in both health care and taxation: it intentionally burdens currently funded consumption.[82] Consumption taxes and sales taxes deliberately burden consumption even more broadly because they do not limit their application to currently funded consumption.[83] Experts generally agree that the benefit of reasonable health care maintenance is not consumption and should not be taxed as such.[84] But sophisticated income tax systems in countries like the United States that do not provide health care through single-payer systems do not live up to this aspiration.

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[80] *See id.* at 1419–22 (discussing the information problem between consumers, providers, and society as one of the endemic problems of the health care industry).

[81] John Rawls famously argued for "justice as fairness," with the connotation that the former and the latter are not interchangeable concepts. HAUSMAN & MCPHERSON, *supra* note 19, at 203–06. This Article uses "fairness" as a synonym for justice or equal treatment of those under the sway of government, and not as a special version of either of these; it does not assume fairness is necessarily Rawlsian.

[82] *See* Joseph Bankman & David A. Weisbach, *The Superiority of an Ideal Consumption Tax over an Ideal Income Tax*, 58 STAN. L. REV. 1413, 1418 (2006) (explaining that a direct tax on earnings reduces the value of the dollar earned, leaving an individual with less to spend).

[83] *See* Edward J. McCaffery, *A New Understanding of Tax*, 103 MICH. L. REV. 807, 824–25 (2005) (discussing postpaid consumption taxation).

[84] *See, e.g.*, William D. Andrews, *Personal Deductions in an Ideal Income Tax*, 86 HARV. L. REV. 309, 335–36 (1972) (justifying medical services deductions by viewing "medical expenses like a loss of earnings"); Michael Grossman, *On the Concept of Health Capital and the Demand for Health*, 80 J. POL. ECON. 223, 225 (arguing that health functions uniquely as both a consumption and investment commodity); McCaffery, *supra* note 83, at 839 (arguing that consumption of medical expenses does not fit the traditional understanding of consumption).

These countries must adjust tax burdens on consumption by exempting taxpayers' acquisition of health care from the income tax, and this is not easily done.

William D. Andrews and subsequent commentators have argued that medical expenses should be deductible, or recoveries that pay these expenses should be excluded, because they restore the individual's basic endowment, the starting point from which income should be measured.[85] The current Code seems to reflect this policy norm by making medical expenses deductible, and by making some, but not all, taxpayers' health insurance tax-free (by exclusion or deduction),[86] but it provides this treatment unequally, discriminating primarily against employees whose employers do not provide them with health insurance as an employment benefit.[87] The ACA would change this apparently incoherent attempt to exempt medical expenses for insurance or treatment from income tax,[88] but it exacerbates one feature of current law that contributes to its incoherence and introduces further elements of inequality among taxpayers. It may be that some of this inequality would be expected to disappear as health insurance markets respond to the ACA, but any prediction to that effect would be based on highly speculative assumptions about those markets.

These weaknesses in the ACA's gesture towards integrating health care policy and tax policy expose a deeper problem related to American health care markets. The balkanization of the health care insurance market between large employer and small employer or single employee policy markets makes the cost of the same health care different for different individuals.[89] These differences prevent costs from reflecting the value of the health care to the individuals. Hence, the tax treatment of these costs preserves the discrepancy between the price and the effect of health care on the individual's well-being.

The approach taken by the pre-ACA income tax was notably inequitable. Although all individuals were allowed to deduct their outlays

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[85] *See, e.g.*, Andrews, *supra* note 13, at 335–37; Thomas D. Griffith, *Theories of Personal Deductions in the Income Tax*, 40 HASTINGS L.J. 343, 393–94 (1989) (advocating medical expense tax deductibility or tax credit); Stanley A. Koppelman, *Personal Deductions Under an Ideal Income Tax*, 43 TAX L. REV. 679, 711–13 (1988) (justifying a tax deduction for medical expenses).

[86] *See* STEPHEN UTZ, INSIDE TAX LAW: WHAT MATTERS AND WHY 202–03 (2011).

[87] *Id.*

[88] Robert Pear & Steven Greenhouse, *Accord Reached on Insurance Tax for Costly Plans*, N.Y. TIMES, Jan. 15, 2010, at A1 (noting that a 40% excise tax on purchase by employer of more expensive health care insurance for employees will be passed on to employees); Robert Pear, *In Health Bill For Everyone, Provisions For a Few*, N.Y. TIMES, Jan. 4, 2010, at A10 (outlining anticipated preservation of special treatment under the ACA for employer-sponsored health care plans).

[89] *See, e.g.*, KAISER FAM. FOUND. & HEALTH, RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2011 SURVEY RESULTS 1, 20 (2011), *available at* http://ehbs.kff.org/pdf/2011/8225.pdf (citing survey results showing average premiums are lower for workers in small firms than for those in large firms).

on most non-elective kinds of health care treatment, these deductions were limited arbitrarily by thresholds based on the taxpayer's adjusted gross income ("AGI"),[90] a feature of the taxpayer's taxable income calculation that has no relationship to health care needs. To make matters worse, the value of employer-provided health insurance, which would otherwise be included in employees' income, has long been excluded from employees' income.[91] As a consequence, taxpayers who must buy health insurance for themselves pay with post-tax dollars, and their health care is therefore treated as taxable consumption, while taxpayers whose employers provide them with health insurance effectively "buy" this insurance with pre-tax dollars, and their health care is *not* treated as taxable consumption.

Section 213 (as it still stands, though scheduled for change) allows a deduction for medical expenses that are not reimbursed by insurance, to the extent that they exceed 7.5% of the taxpayer's AGI.[92] These include expenses for "medical care," defined with some specificity as "amounts paid . . . for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body," as well as related transportation, prescription drugs and insulin, and certain qualified long-term care.[93] The IRS now interprets "treatment . . . of disease" to include in-home services for the care of a chronically ill person, including elderly people with senile dementia or Alzheimer's disease.[94] Insurance for medical care, as defined, and for long-term care can also be deducted.[95] But the 7.5% threshold is so high that most medical expenses, though deductible, yield no tax benefit.[96]

An exclusion of the value of employer-provided health and accident insurance[97] and of the benefits received under such insurance contracts[98] plays a larger role than the medical expense deduction and costs the government a huge amount in foregone tax revenue. Self-employed individuals can deduct the full cost of health insurance against their income from the self-employment,[99] limited only by the deduction for part of the

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[90] I.R.C. §§ 62, 213(a) (2006).

[91] *Id.* § 106; *see* UTZ, *supra* note 10, at 50.

[92] I.R.C. § 213(a).

[93] *Id.* § 213(d).

[94] I.R.S. PUB. NO. 15002Q, *supra* note 16, at 2, 11.

[95] *See* I.R.C. § 213(d)(1) (defining the term "medical care" as amount paid for the treatment or prevention of disease including "qualified long term services").

[96] Mary Beth Franklin, *The Challenge of Deducting Medical Expenses*, KIPLINGER'S PERSONAL FINANCE (Feb. 18, 2011), http://www.kiplinger.com/columns/taxtips/archive/deducting-medical-expenses.html.

[97] *See* I.R.C. § 106(a) (explaining that an employee's AGI does not include "employer-provided coverage under an accident or health plan").

[98] *Id.* § 104(a)(3).

[99] I.R.S. PUB. NO. 15002Q, *supra* note 16, at 24.

self-employment tax they pay,[100] which is a surrogate for wage withholding and roughly equal to it. The upshot is that only employees without employer-provided health insurance are disfavored,[101] mainly by the 7.5% AGI threshold for deducting health insurance premiums.

For example, Jack and Jill, unrelated taxpayers, both have health care insurance. Jack's employer provides him with comprehensive health insurance as an employment benefit. Jill's smaller employer does not, and so Jill buys health insurance for herself and her family with her wages. Jack does not have to report the value of the employer-provided health insurance as gross income for income tax purposes. Jill is entitled to deduct the cost of her insurance on Schedule A as a medical expense, but its cost does not exceed 7.5% of her AGI, and so she effectively pays tax on her insurance because she pays for it with after-tax dollars.

The ACA preserves this discrepancy in tax treatment and worsens it in several respects. Under the ACA, the threshold for deducting medical expenses from 7.5% of AGI increases to 10% in 2014, and the burden on uninsured expenses of chronically ill and for end-of-life in-home care are thereby also increased.[102] On the other hand, the ACA reduces the putative consumption component of expensive plans by taxing insurers that provide them.[103]

The ACA also imposes additional limits on "health savings accounts" ("HSAs") and "flexible spending accounts" ("FSAs"),[104] burdening employees without employer-provided insurance.[105] The significance of these limitations can best be understood in terms of the contrast between what a particular health insurance contract covers and what the insured must pay out of pocket (amounts for which participating health care providers receive no compensation from the insurer or the insured are not in question here). Even if a taxpayer receives health insurance as a benefit that need not be included in gross income for tax purposes, co-pays and deductibles normally come out of the taxpayer's taxed income, just as all the cost of insurance, co-pays and deductibles come out of the taxed

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[100] I.R.C. § 1401.

[101] I.R.S. PUB. NO. 15002Q, *supra* note 16, at 24.

[102] 26 U.S.C.A. § 213 (West 2003 & Supp. 2011).

[103] 42 U.S.C.A. § 18091.

[104] *See Affordable Care Act: Questions and Answers on Over-the-Counter Medicines and Drugs*, IRS, http://www.irs.gov/newsroom/article/0,,id=227308,00.html (last updated Feb. 1, 2012) (noting that under the ACA, FSAs will only cover over-the-counter medicines purchased with a prescription, except for insulin, and that only these two classes of medicines will receive the preferred tax treatment that HSAs afford).

[105] JOINT COMM. ON TAXATION, JCX-17-10, ESTIMATED REVENUE EFFECTS OF THE AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 4872, THE "RECONCILIATION ACT OF 2010," AS AMENDED, IN COMBINATION WITH THE REVENUE EFFECTS OF H.R. 3590, THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT ('PPACA')," AS PASSED BY THE SENATE, AND SCHEDULED FOR CONSIDERATION BY THE HOUSE COMM. ON RULES ON MAR. 20, 2010, 111th Cong. (2010).

income of taxpayers who do not receive excludible health coverage as an employment benefit.[106] Either sort of taxpayer, however, can now avoid some of the tax burden on these out-of-pocket payments if he or she has an HSA or an FSA. With some restrictions, each of these devices allows the taxpayer to divert a certain portion of the wages he or she will receive for the coming year from inclusion in gross income.[107] The amounts diverted can then be used only for statutorily permitted purposes (health care only in the case of the HSA and health care among other purposes for the FSA).[108] The functional outcome is that amounts paid from these pre-tax accounts are never taxed, and co-pays and deductibles are relieved of tax burden.

The ACA, as these details show, gestures at tax equity for participants in private health care markets by making adjustments that depend on irrelevant attributes of health care recipients (e.g., their AGI or whether their employers provide health care insurance) just as earlier tax law did. Equal access to beneficial health care is the gold standard of equal treatment, and the tweaking of ill-assorted deductions and unjustified exclusions is, by that standard, at best a placebo, perhaps even a harmful counterfeit. If there is any value to these features of the ACA, it is the implicit acknowledgment that tax burdens matter and that the tax law falls short of one of its most basic goals, the equitable distribution of tax burdens, when governmental health care policy makes post-tax income a significant determinant of access to health care.

What is glaringly absent from the ACA is an acknowledgment that equal treatment for all requires that some basic package of health care benefits be given to everyone, untrammeled by economic hurdles. The Internal Revenue Code is not the ideal location for rules designed to achieve this, and indeed the ACA makes no serious effort to use it as such. Unfortunately, there is evidence that the expanded availability of health insurance to those with pre-existing conditions is already falling short of its goal because some who qualify cannot afford to take buy the available coverage.[109]

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[106] *See* I.R.C. § 106(a) (providing that "gross income of an employee does not include employer-provided coverage under [a] . . . health plan"); *id.* § 105(a) ("[A]mounts received by an employee through . . . health insurance for personal injuries or sickness shall be included in gross income to the extent such amounts (1) are attributable to contributions by the employer which were not includible in the gross income of the employee, or (2) are paid by the employer.").

[107] *See id.* §§ 125, 223 (setting limited deductions for "Cafeteria Plans" and "Health Savings Accounts," respectively).

[108] *Id.*

[109] ROBIN A. COHEN ET AL., FINANCIAL BURDEN OF MEDICAL CARE: EARLY RELEASE OF ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY, JANUARY–JUNE 2011 1 (March 2012), *available at* http://www.cdc.gov/nchs/data/nhis/earlyrelease/financial_burden_of_medical_care_032012.pdf (many cannot afford health care despite the ACA's extension of health insurance availability); *see* Ann Carrns, *Many Americans Struggling to Pay Medical Bills*, BUCKS (March 18,

V. CONCLUSION

Existing tax law and the ACA exclude health care insurance or make its cost deductible.[110] The income that pays for uninsured health care outlays (e.g., coinsurance, deductibles) is effectively taxed unless the taxpayer has an HSA or a health expense FSA or the "basic" insurance subsidized under the ACA for low to moderate income households.[111] Other provisions of the ACA eliminate copays and deductibles for some individuals.[112] Nevertheless, the ACA increases the tax burden on some health care insurance coverage—obviously so in the case of coverage that is much more generous than the ACA deems basic.[113] Perhaps this is part of an implicit strategy for reducing moral hazard, or it may only be a "consumption" correction, i.e., a tax-policy-based adjustment designed to ensure that elective use of health care is properly classified as consumption and, for that reason, included in the taxpayer's income.

Further exclusions for health care insurance and uninsured outlays would be needed to preserve non-consumption status of health care. But *inclusions* of some portion of the value of low-cost large-employer-provided health coverage would also be needed, precisely because the market price of this coverage is much lower than the market price of so-called "tailored" plans—which individuals must buy for themselves.[114] The ACA may change these market conditions, but it provides no direct mechanism for doing so. Presumably, governmentally provided insurance would not be taxed, so there would be no inherent problem of coordination with respect to the coverage or benefits flowing to taxpayers from this feature of the ACA.

2012, 2:15 PM), http://bucks.blogs.nytimes.com/2012/03/20/many-americans-struggling-to-pay-medical-bills/.

[110] *See* I.R.C. § 106(a) (excluding employer-provided coverage from gross income); *id.* § 213(a) (allowing deduction for "medical expenses . . . not compensated for by insurance or otherwise, . . . to the extent that such expenses exceed 7.5% of adjusted gross income"); *see also* 26 U.S.C.A. § 4980I (West 2003 & Supp. 2011) (imposing excise tax on employer-sponsored health coverage).

[111] 42 U.S.C.A. 18051.

[112] *E.g.*, *id.* § 1395I.

[113] *See, e.g.*, 26 U.S.C.A. §§ 125, 213, 3101, 4001, 4980I (respectively, limiting the amount of contributions to health flexible spending accounts to $2,500 per year; raising the level of expense necessary for deduction under I.R.C. § 213 from 7.5% to 10% of adjusted gross income; imposing additional hospital tax on high-income taxpayers; imposing annual fees on health insurance providers; and imposing excise tax on employer-sponsored health coverage).

[114] *See* Bradley W. Joondeph, *Tax Policy and Health Care Reform: Rethinking the Tax Treatment of Employer-Sponsored Health Insurance*, 1995 BYU L. REV. 1229, 1249 (arguing that individually underwritten insurance is extremely expensive, offers less comprehensive coverage, and must be purchased with after-tax dollars, making it less favorable than employment sponsored insurance); *see also* PAUL N. VAN DE WATER, CTR. ON BUDGET & POL'Y PRIORITIES, LIMITING THE TAX EXCLUSION FOR EMPLOYER-SPONSORED INSURANCE CAN HELP PAY FOR HEALTH REFORM (June 4, 2009), *available at* http://www.cbpp.org/cms/index.cfm?fa=view&id=2832 (arguing that the tax exclusion of employer-provided health insurance is poorly targeted and leads to an increase in health care spending).

From 1986 through the ACA's effective dates, nothing had been done to integrate them comprehensively. Details of the ACA may provide a better approximation of integrated policy, but such integration is still biased in favor of the employed, and against retirees and the temporarily unemployed.[115] A single-payer system, even with co-pays, would make the solution straightforward. Unfortunately, the political impossibility of that alternative makes the complex task of revising tax policy not only more difficult, but challenging at the most fundamental level. A replacement for utility theory must be found if the government's intervention to improve individuals' well-being is to achieve principled fairness.

[115] *See* Blaine G. Saito, Note, *The Value of Health and Wealth: Economic Theory, Administration, and Valuation Methods for Capping The Employer Sponsored Insurance Tax Exemption*, 48 HARV. J. ON LEGIS. 235, 245 (2011) (highlighting the vertical and horizontal equity problems created by the exemption under the ACA for employment sponsored insurance).